PRIMARY CARE SERVICES MANUAL

Kentucky Medical Assistance Program
Primary Care Benefits
Policies and Procedures

Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

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SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medical Assistance Program Primary Care Services Manual has been formulated with the intention of providing you, the provider with a useful tool for interpreting the procedures and policies of the Kentucky Medical Assistance Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will, hopefully, assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Policy and Provider Services, Department for Medicaid Services, Cabinet for Human Resources, CHR Building, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 372-2921 or (502) 227-2525.

SECTION I - INTRODUCTION

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

SECTION II - KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

II. KENTUCKY MEDICAL ASSISTANCE PROGRAM (KMAP)

A. General

The Kentucky Medical Assistance Program, frequently referred to as the Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U. S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services provided to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medical Assistance Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. KMAP cannot reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medical Assistance Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal program, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual in Section IV.

B. Administrative Structure

The Department for Medicaid Services, Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. KMAP makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been provided to eligible recipients.

Determination of the eligibility status of individuals and families for Medical Assistance benefits is a responsibility of the local Department for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medical Assistance Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of seventeen members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining sixteen members are appointed by the Governor to four-year terms. Nine members represent the various professional groups providing services to Program recipients, and are appointed from a list of three nominees submitted by the applicable professional associations. The other seven members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five-member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization that the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medical Assistance Program hereinafter referred to as KMAP, is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Programs have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medical Assistance Program is payor of last resort. Accordingly, the provider of service should seek reimbursement from such third party groups for medical services provided. If you, as the provider, should receive payment from the KMAP before knowing of the third party's liability, a refund of that payment amount should be made to the KMAP, as the amount payable by the Cabinet shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers must agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap, or age.

Each medical professional is given the choice of whether or not to participate in the Kentucky Medical Assistance Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his or her medical care.

When the Cabinet makes payment for a covered service and the provider accepts the payment made by the Cabinet in accordance with the Cabinet's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment. Stamped signatures are not acceptable.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

A provider's adherence to the policies in this manual are monitored through either post-payment review by the Department or by computer audits and edits. When computer audits or edits fail to function properly the policies in this manual remain in effect and thus become subject to post-payment review.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical specialty.

All services are reviewed for recipient and provider abuse. Willful abuse by the provider may result in his or her suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he or she receives.

No claim may be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims will be paid for services that required, but did not have, prior authorization by the Kentucky Medical Assistance Program.

No claims may be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and such payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603

Section 1909. (a) Whoever--

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting (A) his initial or continued right to any such benefit or payment, or (B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person,

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eligibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person--

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility,

when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Timely Submission of Claims

In order to receive Federal Financial Participation, claims for covered services rendered eligible Title XIX recipients must be received by the EDS within twelve (12) months from the date of service. Claims received after that date will not be payable. This policy became effective August 23, 1979.

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Definition and Intent

1. The Primary Care Services element of the KMAP was developed in recognition of a need for comprehensive ambulatory health care services in a single setting, with the ultimate objective being the improvement of the general health of the recipients served by participating primary care centers. It is expected that this form of patient management will effectively result in a reduction in hospital stays and institutional patient care.

2. On-site care, focusing on the general ongoing health needs of the center's patients with emphasis on preventive and maintenance health measures, is provided by a team of medical and allied health personnel skilled in meeting a variety of family health and health related needs.

3. The center serves as the primary health resource for the patient and his family, arranging for referral to and acceptance of the patient by the appropriate provider when the specific need cannot be met directly by the center. Comprehensiveness and continuity of care are assured by the establishment and periodic updating of a written plan of care for each patient/family served by the center.

4. The primary care center is actively involved with health and health-related concerns of the community and makes health education available to the total community.

SECTION III - CONDITIONS OF PARTICIPATION

B. Participation Requirements

1. To participate as a reimbursable health provider under the primary care services element of the KMAP, each primary care center will be required to meet the standards established for licensure, be licensed by the Certificate of Need and Licensure Board, and meet the additional requirements set forth in State Regulation 907 KAR 1:054.

2. Out-of-State primary care centers applying for participation must be licensed by the appropriate agency of the State in which they are located, if applicable, and in addition must meet the standards set forth by the Kentucky Certificate of Need and Licensure Board and State Regulation 907 KAR 1:054.

3. Medical services rendered eligible Title XIX recipients must be provided by or under the direct supervision of a staff professional who is appropriately licensed by Kentucky or the State in which the center is located. This professional must render only those services which are within the scope of services authorized by the license.

4. The Primary Care Center licensure regulation provides the minimum basis for designation as a primary care center. The Title XIX Program regulation reinforces these licensure requirements, specifies a wider range of services which will be reimbursable for Medicaid eligibles and provides certain limitations with respect to reimbursable services.

5. The Title XIX Program specifications require participating primary care centers to provide a program of basic services which shall include medical, diagnostic and treatment service for all age groups; treatment of injuries and other traumas; prenatal and postnatal care; a program of preventive health

services which must include well-baby care, and immunizations and which may include other types of preventive care; referral services; health education services; and the direct professional services of a dentist, clinical pharmacist and optometrist or a substitution on a one for one basis for any or all of the preceding three services by an identifiable program for providing family planning services, home health services, social service counseling, pharmacy services (may not be used as a substitute if clinical pharmacist is selected as a basic service), nutritional services, or nurse midwifery services. In addition to the basic services, a primary care center may provide other supplemental services such as holding and observation accommodations, any of the alternate basic services indicated above, outreach services and other ambulatory services within the scope of the Medical Assistance Program, except for institutional care.

6. Having met such requirements, a primary care center is required to enter into a participation agreement with the Cabinet and be issued a notification of participation. Such participation agreement may be nullified by the Cabinet with appropriate prior notice if at any time a primary care center fails to meet a condition of participation or licensure.

   An application for participation shall include:

   a. The Provider Agreement (MAP-343)
   b. Provider Information Sheet (MAP-344)
   c. Certification of Conditions Met (MAP-346)
   d. Statement of On-Site Services (MAP-231)
   e. Statement of Authorization (MAP-347). Attach a copy of the license of each licensed professional on staff.
   f. Annual cost report as outlined in the Primary Care Reimbursement Manual.

The completed participation documents, signed by the administrator of the center, must be submitted to the Department for Medicaid Services and subsequently approved, prior to receiving reimbursement for services rendered eligible Program recipients. A provider number and the center's interim rate of payment (CAC) will be included with the notification of participation approval by the Department for Medicaid Services.

7. Concurrent with the effective date of participation in the Primary Care Services element of the Program, the Center will cease to submit billings to any other element of the KMAP for services rendered Title XIX recipients.

   If the Center currently submits billings to other elements of the KMAP, a letter from the Center administrator will also be required to terminate other KMAP participation agreements.

8. All physicians/dentists/other licensed professionals must have current valid licenses to practice in the state of Kentucky at the time medical services/procedures are performed.

9. The physician/other licensed professional whose KMAP provider number is entered in Block #17 of the MAP-7 as the professional rendering the service must have patient contact for each service billed.

10. Medical Records: Medical records in the primary care center must substantiate the services billed to the KMAP. The medical records must be accurate and appropriate and entered personally or countersigned by the professional who rendered the service. All records must be signed and dated. Stamped signatures are not acceptable.

    The results of diagnostic testing, including negative test results, must be indicated in the medical record of the patient. The date of the test shall be the same date for which the KMAP is billed.

Medical records must be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit exception or other dispute. The records and any other information regarding payments claimed must be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and/or copying by Cabinet personnel.

11. The Medical records of the patient in the hospital must document through signed or countersigned notes that the billing physician did one or more of the following:

    a) personally reviewed the patient's medical history;
    b) performed a physical examination;
    c) confirmed or revised the diagnosis;
    d) face-to-face encounter with the patient;
    e) discharged the patient.

C. Termination of Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medical Assistance Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standards;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medical Assistance Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medical Assistance Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving such notice may request an evidentiary hearing. The request must be in writing and made within five (5) days of receipt of the notice.

If a provider is terminated from KMAP participation, services after the effective date of termination are not payable.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following:

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medical Assistance Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medical Assistance Program. Adverse action taken against an individual provider under Medicare must be appealed through Medicare procedures.

SECTION IV - SERVICES COVERED

IV. SERVICES COVERED

Each Primary Care Center shall provide directly to eligible program recipients on a regular, full-time basis the basic services, and may provide one or more of the supplemental services.

A. Basic Services

1. Medical diagnostic and treatment services for all age groups as provided by a physician or nurse practitioner.

2. Treatment of injuries and minor trauma.

3. Prenatal and postnatal care.

4. A program of preventive health services to include well-baby care and immunizations. It may also include other types of preventive care.

5. Referral services designed to ensure the referral to and acceptance by an appropriate medical resource, when services necessary to the health of the patient are not provided directly by the center.

6. Health education services which must provide, as a minimum, appropriate personnel to present, on request, information on general health care to local school systems, civic organizations and other concerned local groups. Services are to include distribution of written material on pertinent health subjects.

7. The direct professional services of the following:

   a. Dentist,

   b. Clinical Pharmacist, and

   c. Optometrist.

8. Any of the following services may substitute on a one for one basis for the services shown in "7." above, when provided directly by the center in the context of an identifiable program by appropriately trained personnel (further requirements are detailed under description of each service).

   a. Family planning services

   b. Home health services

   c. Social services counseling

   d. Pharmacy services - If clinical pharmacist is selected as a basic service in "7."; pharmacy services may not be used as a substitute for remaining requirements in "7."

   e. Nutritional services

   f. Nurse midwifery services

B. Supplemental Services

1. Services within the scope of the Medical Assistance Program, excluding institutional care, which are not provided as basic services.

2. Holding observation accommodations.

3. Outreach Services - These services must be provided as a package structured to identify health care needs in the service area.

SECTION IV - SERVICES COVERED

C. Non-Covered Services

1. All institutional services

2. Housekeeping, babysitting, and other homemaker services of like nature

3. Services which are not provided in accordance with restrictions imposed by law OR regulation.

4. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to provide or to make payment.

NOTE: Limitations and Prior Authorization

1. Limitations in covered services are addressed within the description of each specific category of service.

2. Services requiring prior-authorization are explained within the description of each specific category of service.

Additional questions regarding limitations and/or prior authorizations for specific services should be directed to the Cabinet for Human Resources, Department for Medicaid Services, Division of Policy and Provider Services, Frankfort, Kentucky 40621 or phone (502) 564-6890.

D. Medical

Diagnostic and treatment services (within the scope of their licensure) as provided by a physician and Advanced Registered Nurse Practitioner (ARNP) on the staff of the Primary Care Center.

1. Exclusions from Coverage

a. Procedures purely for cosmetic purposes
b. Any service not performed in compliance with State and Federal requirements
c. Autopsy procedures

d. Telephone contacts
e. Contacts between primary care center employees and recipients for purposes of obtaining prescriptions or prescription refills when obtaining medication is the only service provided. (This does not include dispensing of prescriptions.)

2. Inpatient Admissions

Program coverage for hospital inpatient care is limited to a maximum of fourteen (14) days per admission. All admissions are subject to approval by the Peer Review Organization and must be within the scope of covered services.

In order to be considered a "covered inpatient admission" by the KMAP, an admission must be primarily for treatment indicated in the management of an acute or chronic illness, injury or impairment, or for obstetrical care. The KMAP can only provide reimbursement for services which are certified as being medically necessary and within the scope of coverage. The KMAP does not cover what is commonly called "Administratively Necessary Days" (A.N.D.) days of hospitalization for reasons other than medical indications, such as awaiting long term care facility placement.

NOTE: If the admission is determined by the KMAP to be a "non-covered" admission, neither the hospital nor the Primary Care Center will be reimbursed by the KMAP for that admission. Those admissions primarily for elective procedures or cosmetic procedures are excluded from coverage by the Program unless medically necessary or indicated.

Hospital admissions for diagnostic procedures can be reimbursed only when there is adequate documentation that the procedures cannot be performed on an outpatient basis. Readmissions are payable only when an acute worsening of an existing condition occurs, or when an entirely new condition develops requiring hospitalization primarily for treatment indicated in the management of acute or chronic illness, injury or impairment or for obstetrical care. Written descriptive verification of the recipient's condition necessitating readmission may be required before such readmission can be considered for payment.

All non-emergency hospital admissions must be pre-authorized by PEERVIEW in order for the KMAP to reimburse the admitting hospital. Prior to the proposed admission, a responsible person in the primary care center's office must contact the PEERVIEW office for pre-admission review. PEERVIEW office staff will assign the initial number of days allowed for the type of admission and provide the pre-admission authorization number. The number of days allowed is considered the standard length of stay for the type of admission barring complications. Both the pre-authorization number and the days approved should be given to the hospital during admission procedures. Emergency admissions and deliveries do not require a pre-authorization number. Extensions beyond the initial number of days require no action on the part of the primary care center. This is a process between PEERVIEW and the hospital.

The toll-free phone number for PEERVIEW KMAP pre-admission reviews is 1-800-423-6512. This number is answered Monday through Friday 8:00-5:30 central time and 9:00-6:30 eastern time.

3. Sterilizations

The KMAP will make payment for sterilizations only when the following conditions are met:

a. The recipient voluntarily requests the procedure and is advised at least thirty days BEFORE the sterilization procedure of the nature of the sterilization procedures to be performed, of the alternative methods of family planning and of the discomforts, risks, and benefits associated with it. Also, the recipient must be advised that his/her consent to be sterilized can be withdrawn at any time and will not effect his/her entitlement to benefits provided by Federal funds.

b. The recipient signs a Sterilization Consent Form (MAP-250) and is advised that a decision not to be sterilized will not affect his or her entitlement to benefits under any government assistance program. The Sterilization Consent Form must be signed by the recipient and the person obtaining the consent at least thirty days before the surgery except in the case of premature delivery or emergency abdominal surgery. An individual may consent to be sterilized at the time of a premature delivery or emergency abdominal surgery, if at least 72 hours have passed since he or she gave informed consent for the sterilization. In the case of premature delivery, the informed consent must have been given at least 30 days before the expected date of delivery. No more than one hundred and eighty (180) days may elapse between the date the consent form is signed and the date on which the procedure is performed.

c. The recipient is twenty-one (21) years old or older, at the time of signing the consent form.

d. The recipient must not have been legally declared mentally incompetent unless he or she has been declared competent for purposes which include the ability to consent to sterilization; or must not be institutionalized. The fact that a facility is classified as an SNF, ICF or ICF/MR is not necessarily determinative of whether persons residing therein are "institutionalized." A person residing in an SNF, ICF, or ICF/MR is not considered to be an "institutionalized individual" for the purposes of the regulations unless that person is either: (a) involuntarily confined or detained under a civil or criminal statute in one of those facilities; or (b) confined under some form of a voluntary commitment, and the facility is a mental hospital or a facility for the care and treatment of mental illness.

e. The physician who performs the procedure must sign and date the form MAP-250 AFTER the sterilization procedure is performed.

f. Interpreters must be provided when there are language barriers, and special arrangements must be made for handicapped individuals.

g. To reduce the chances of sterilizations being chosen under duress, a consent may not be obtained from anyone in labor or childbirth, under the influence of alcohol or other drugs, or seeking or obtaining an abortion.

h. These regulations apply to medical procedures performed for the purpose of producing sterility.

i. Reimbursement is not available for hysterectomies performed for sterilization purposes.

j. ALL applicable spaces of form MAP-250 must be completed and the form must accompany all claims submitted for payment for a sterilization procedure.

In those cases where a sterilization is performed in conjunction with another surgical procedure (e.g., cesarean section, cyst removal) and compliance with Federal regulations governing payment for the sterilization has not been met, EDS can only make payment for the non-sterilization procedures.

Medical documentation must be attached to the back of the MAP-7 claim form when a procedure is billed to the KMAP which could possibly result in sterilization, but because it is unilateral does not result in sterilization.

See Appendix XIII for a copy of the MAP-250 and instructions for completion of the form.

4. Hysterectomies

Title XIX funds can be expended for hysterectomies that are medically necessary only under the following conditions:

a. The person who secures the authorization to perform the hysterectomy has informed the individual and her representative, if any, orally and in writing, that the hysterectomy will render her permanently incapable of reproduction; and

b. The individual or her representative, if any, has signed and dated the Hysterectomy Consent Form (MAP-251).

c. This Hysterectomy Consent Form (MAP-251) must accompany all claims submitted for payment for hysterectomies, except in the following situations:

(1) The individual was already sterile at the time of the hysterectomy; or

(2) The individual required a hysterectomy because of a life-threatening emergency in which the physician determined that prior acknowledgement was not possible.

The physician must certify in writing either the cause of the previous sterility, or that the hysterectomy was performed under a life-threatening emergency situation in which he or she determined prior acknowledgement was not possible. The physician must also include a description of the nature of the emergency. Such documentation must accompany any hysterectomy procedure for which a Hysterectomy Consent form (MAP-251) was not obtained.

d. If the service was performed in a period of retroactive eligibility, the physician must certify in writing that the individual was previously informed that the procedure would render her incapable of reproducing, or that one of the exempt conditions was met.

See Appendix XIV for a copy of the MAP-251 and instructions for completion of the form.

5. Abortion, Miscarriages and Induced Premature Births

KRS 205.560 specifies the conditions under which the KMAP can make payment for induced abortions, induced miscarriages and premature births for Title XIX recipients.

The law states in part that Title XIX Program payment cannot be made "where such aid is for the purpose of obtaining an abortion, induced miscarriage or induced premature birth unless in the opinion of a physician such a procedure is necessary for the preservation of the life of the woman seeking such treatment or except an induced premature birth intended to produce a live viable child and such procedure is necessary for the health of the mother or her unborn child."

The appropriate certification forms (MAP-235 or MAP-236), indicating the procedure used and signed by the physician, must accompany all invoices requesting payment for these services.

See Appendix XVII for copies of the MAP-235 and MAP-236.

6. Gastric Bypass Surgery

Gastric bypass surgery and other such procedures, including the jejunoileal bypass procedure and gastric stapling, are considered possibly cosmetic procedures and therefore are non-payable unless they meet all of the following criteria:

a. There is documentation that the recipient suffers from other conditions to an extent dangerous to his/her health, e.g. high blood pressure, diabetes, coronary disease, etc.

b. There is documentation that all other forms of weight loss have been exhausted, with legitimate efforts on the part of the physician and recipient, i.e. dieting, exercise, and medication.

c. There is documentation that the sources of weight gain have been identified and subsequently, treatment was attempted in accordance with the diagnosis.

d. There is documentation that prior to the surgery at least one (1) other physician besides the surgeon has been consulted and has approved of the surgical procedure as a last resort of treatment.

e. The recipient is at least 100 pounds over the maximum weight of his/her height and weight category as determined by the attending physician.

It is necessary that the above information accompany each claim submitted for these procedures.

7. Consultations

All consultations billed to the KMAP must include physician/patient contact. Consultations without physician/patient contact are not billable services.

Consultations must have resulted from a specific referral request and have written communication between the consulting and referring physicians as to the results of the examination or evaluation of the recipient. This will be monitored through post-payment review.

The name or KMAP provider number of the referring physician must be indicated in Block #8 of the MAP-7 claim form.

8. Chemotherapy Drugs

(The cost of the Chemotherapy drug only, not to include the administration. Procedure codes for the administration of chemotherapy drugs can be found in the CPT-4 book).

PROCEDURE	DESCRIPTION
J9000	Adriamycin, Doxorubicin HCl, 10 mg. vial
J9010	Adriamycin, Doxorubicin HCl, 50 mg. vial

PROCEDURE	DESCRIPTION
J9020	Asparaginase, Elspar up to 10,000 units
J9040	Blenoxane, Bleomycin Sulfate, 15 units
J9050	Carmustine, Bischlorethyl Nitrosourea, BCNU, 100 mg vial
J9060	Cisplatin, Platinol, 10 mg. vial
J9062	Cisplatin, Platinol, 50 mg. vial
J9070	Cyclophosphamide Cytoxan 10 cc or 100 mgm
J9080	Cyclophosphamide Cytoxan 20 cc or 200 mgm
J9090	Cyclophosphamide Cytoxan 30 cc or 500 mgm
J9091	1.0 Gram Cytoxan
J9092	2.0 Gram Cytoxan
J9093	100 mg. Lyophilized Cytoxan
J9094	200 mg. Lyophilized Cytoxan
J9095	500 mg. Lyophilized Cytoxan
J9096	1.0 Gram Lyophilized Cytoxan
J9097	2.0 Gram Lyophilized Cytoxan
J9100	Cytarabine Hydro-Chloride Arabinosyl Cytosine; Cytosar, 100 mgm
J9110	Cytarabine Hydro-Chloride Arabinosyl Cytosine; Cytosar, 500 mgm
J9120	Dactinomycin, Actinomycin D, Cosmegen, 3cc/0.5 mg.
J9130	Dacarbazine, DTIC, Dome, DIC, 100 mgm
J9140	Dacarbazine, DTIC, Dome, DIC, 200 mgm
J9150	Daunorubicin, Daunomycin; Rubidomycin Cerubinone
J9160	Delautin, ICC, 250 mgm
J9162	Depo-Provera AQ., up to 1000 mgm
J9165	Diethylstilibestrol Diphosplate .25 mg/5 ml.
J9170	Drolban, Dromostanolone, Propionate, 5 mg/10 ml
J9180	Estradurin 40 mg/2 ml
J9181	Etoposide, up to 50 mg.
J9182	Etoposide, up to 100 mg.
J9190	Fluorouacil, 5FU, 500 mgm amp
J9200	Floxuridine FUDR 500 mg.
J9212	Interferon
J9230	Mechlorethamine Nitrogen Mustard; HN 2; Mustargen, 20 cc or 10 mgm

PROCEDURE	DESCRIPTION
J9240	Medroxyprogesterone Acetate, Depo-Provera, 400 mg/ml
J9250	Methotrexate Sodium MTX 2 cc or 5 mg.
J9260	Methotrexate Sodium MTX 2 cc or 50 mg.
J9270	Mitracin Mitramycin 2500 mcg
J9280	Mutamycin, Mitomycin, 5 mg
J9290	Mutamycin, 20 mg
J9295	Polyestradiol Phosphate 40 mg.
J9310	Stilphostrol 0.25 gm/5 ml
J9320	Steptozotocin
J9340	Thio Tepa Triethylenethosphoramide 15 mgm
J9350	Thytropar, Thyroid Cancer, 10 Unit Vial
J9360	Vinblastine Sulfate Velban 10 cc or 10 mg.
J9370	Vincristine Sulfate, Oncovin 01 mgm.
J9375	Vincristine Sulfate, 2 mg/2 ml (2 ml vial)
J9380	Vincristine Sulfate, Oncovin 5 mgm
J9999	Not Otherwise Classified, Anti-neoplastic Drugs

9. Procedural Coding

The Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS) is utilized by the Program for procedural coding purposes to identify medical services rendered eligible recipients. The HCPCS codes consist of three major sections: national codes, local codes, and CPT-4 codes. The national and local codes, applicable to primary care services, can be found under the appropriate service element in this manual. The CPT-4 codes are listed in the CPT-4 Procedure Coding Manual which can be obtained at the following address:

CPT-4th Edition
Order Dept. OP-341-5
American Medical Association
P.O. Box 10946
Chicago, Illinois 60610

Telephone Number: 1-800-621-8335

SECTION IV - SERVICES COVERED

Below are procedures listed in the CPT-4 coding book which are NOT covered by the KMAP Primary Care Program.

NON-COVERED PROCEDURE CODES

PROCEDURE CODES	DESCRIPTION
00100-01999	Anesthesia Procedures
11920-11954	Tattooing Procedures
15875	Suction assisted lipectomy, any site(s)
19355	Correction of inverted nipples
54235	Injection of corpora cavernosa with pharmacologic agent(s) (e.g., papaverine, phentolamine, etc.)
55970	Intersex surgery
55980	Intersex surgery
59050	Initiation and/or supervision of internal fetal monitoring during labor by consultant
59400	Total Obstetric Care includes antepartum care, vaginal delivery and postpartum care
69090	Ear piercing
76001	Fluorscopy, physician time more than one hour, assisting a non-radiologic physician (e.g. nephrostolithotomy, ERCP, bronchoscopy, transbronchial biopsy)
76948	Ultrasonic guidance for aspiration of ova, supervision and interpretation only
76949	Complete procedure
78890	Generation of automated data
78891	Complex manipulations and interpretation
78990	Provision of diagnostic radionuclide(s)
88000-88099	Anatomic Pathology Postmortem Examination
89329-89330	Sperm Evaluation

PROCEDURE CODES	DESCRIPTION
90749	Unlisted Immunization Injections
90780	IV infusiton therapy; up to one hour
90781	Each additional hour
90799	Unlisted Therapeutic Injection
90880-90889	Other Psychiatry Therapy
92314-92326	Contact Lens Services
92330	Ocular Prosthetics, Artificial Eye
92335	Ocular Prosthetics, Artificial Eye
92342	Spectacle Services (Including Prosthesis for Aphakia)
92353	Spectacle Services (Including Prosthesis for Aphakia)
92354	Spectacle Services (Including Prosthesis for Aphakia)
92355	Spectacle Services (Including Prosthesis for Aphakia)
92358	Spectacle Services (Including Prosthesis for Aphakia)
92390-92396	Supply of Materials
92953	Temporary Transcutaneous Pacing
95135	Allergen Immunotherapy
95150	Allergen Immunotherapy
95170	Allergen Immunotherapy
95199	Allergen Immunotherapy
99000-99015	Administrative Services
99024	Administrative Services
99025	Administrative Services
99052	Administrative Services
99054	Administrative Services
99056	Administrative Services
99058	Administrative Services
99070	Administrative Services
99071	Administrative Services
99075	Administrative Services
99078	Administrative Services
99080	Administrative Services
99090	Administrative Services

SECTION IV - SERVICES COVERED

PROCEDURE CODES	DESCRIPTION
99100-99140	Qualifying Circumstances for Anesthesia
99154	Daily Hospital management of epidural or subaracunoid drug administration
99155	Medical conference; 25 minutes
99156	Medical conference; 50 minutes

Only services actually performed can be billed for. The procedure code which most accurately and completely describes the service performed is to be selected for billing purposes to the KMAP. The charge made to the KMAP should be the same charge made for comparable services provided to any party or payor.

10. The following lists laboratory procedures that can be billed by either a licensed physician (M.D.) or Advanced Registered Nurse Practitioner (ARNP) if the primary care center does not have a certified laboratory and technicians on-site and the services are rendered on-site directly by the M.D. or ARNP.

PROCEDURE	CODE NUMBER
Throat Cultures (Screening)	87081; 87082; 87083; 87084; 87085
Smears for Bacteria, Stained	87205
Bleeding Time	85000; 85002
Red Blood Count	85041
Hemoglobin	85018
White Blood Count	85048
Differential	85007; 85009
Complete Blood Count	85021; 85022; 85028; 85031; 85023*, 85024*, 85025*
Hematocrit	85014
Platelet Count	85580; 85585; 85590; 85595
Prothrombin Time	85610; 85612; 85614
Sedimentation Rate	85650; 85651
Glucose (Blood)	82947; 82949; 84948
Blood Urea Nitrogen	84520; 84525; 84540
Uric Acid	84550
Urine Analysis (Chemical and Microscopic)	81000; 82615
Thyroid Profile	84435; 84443; 84437; 84800; 82756; 84479
Glucose Tolerance	82951, W8724, 82952
Electrolytes	80003; 80002
Ova and Parasites	87177
TB Tests	86585; 86580

*These codes are effective for claims with dates of service on or after 12/01/87.

SECTION IV - SERVICES COVERED

PROCEDURE	CODE NUMBER
Coccidioidomycosis	86490
Histoplasmosis	86510
Mumps	86540
Brucella	86002
Fine needle aspiration with or without preparation of smear; superficial tissue	88170
Deep tissue with radiological guidance	88171
Evaluation of fine needle aspirate with or without preparation of smears	88172
Duodenal intubation and aspiration: single specimen	89100
Multiple specimens	89105
Gastric intubation and aspiration: diagnostic	89130; 89132; 89136; 89140; 89141
Nasal smears for eosinophils	89190
Sputum, obtaining specimen, aerosol induced technique	89350

The following procedures are payable only when performed by a Board-Certified pathologist, oncologist or hematologist:

Bone Marrow spear and/or cell block; aspiration only	85095
Smear interpretation only	85097
Aspiration, staining and interpretation	85100
Aspiration and staining only	85101
Bone Marrow needle biopsy	85102
Staining and interpretation	85103
Interpretation only	85105

This policy is subject to post-payment review.

A Complete Blood Count (CBC) must be used when billing 3 or more of the following tests: 85007 or 85009, 85041, 85018, 85048, or 85014. When three or more components are performed, the CBC must be billed, and no additional component is allowed.

The KMAP does not cover urinalysis, unless it includes a microscopic examination. By definition this code, when billed, indicates that a total urinalysis with microscopic examination has been performed. "Dipstick" urinalyses are NOT reimbursable by KMAP.

A culture and a smear for bacteria may not both be billed the same date of service for the same diagnosis code.

11. Newborn Care

Services for a newborn are to be billed under the mother's name and MAID number for ROUTINE newborn care and for newborn circumcision. Enter "For Baby (Boy or Girl _____)" in the procedure description for any newborn services billed under the mother's name and MAID number. Routine newborn care should be billed only once per 12 month period.

12. Fetal Testing

Fetal testing procedures are limited to any combination of three (3) tests per twelve (12) month period, per recipient. If more than three (3) tests are billed within a twelve (12) month period for the same recipient, medical documentation justifying the necessity will be required.

13. Limitations on Covered Emergency Room Visits

Payment for I.V.s, venipunctures, and the interpretation of routine procedures (laboratory and radiology tests, E.K.G., etc.) is included in the payment for the emergency room visit; therefore, these procedures should not be billed separately. This policy is subject to post-payment review.

14. Lock-In Recipients

The Lock-In Program was implemented for recipients who have been identified as using physician and/or pharmacy services inappropriately. Utilization review of recipient participation patterns demonstrates exceptional or excessive use of these Program benefits. Recipients in this category are placed in the Lock-In Program to assist them in establishing: (a) a physician-patient relationship, (b) continuity of care, and (c) to safeguard against the dispensing of contraindicated drugs by multiple physicians and pharmacies.

In order to accomplish these goals, all Lock-In recipients are subject to the following limitations in covered services:

a. Recipients who are selected for Lock-In receive special PINK Medical Assistance Identification cards each month. Physician and/or pharmacy services must be provided by the Lock-In provider only.

b. Physician and/or pharmacy services rendered by persons other than the Lock-In provider are considered non-covered services except as follows:

(1) The recipient requires physician services at an emergency room, in-patient or out-patient hospital, community mental health, family planning, etc.

(2) The recipient requires treatment due to an acute illness, arising after hours, weekends, holidays. Claims will be considered if documentation is provided that indicates the medical necessity of the service (i.e., Lock-In provider not available, injury/accident, recipient out of town).

(3) The recipient's Lock-In provider determines that the services of a consultant OR specialist are medically necessary. This includes second opinions for surgery, etc. Claims will be considered for payment if the name and number of the Lock-In provider are entered in Block #8 of the MAP-7 claim form.

c. The recipient will remain on the Lock-In Program until payment profiles indicate that the recipient's utilization pattern is within acceptable parameters. The recipient is not permitted to change Lock-In providers unless:

(1) The recipient or provider moves;

(2) The provider requests a change; or

(3) Sufficient evidence is provided to indicate that a change is in the best interest of the recipient.

Physicians are encouraged to notify the Department for Medicaid Services regarding specific cases of apparent inappropriate utilization of Program benefits. Recipient utilization profiles are then developed for consideration of recipient inclusion in the Lock-In Program.

15. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medical Assistance Program (KMAP), provides certain categories of medical recipients with a primary physician or family doctor. Only those Medicaid recipients who receive medical assistance under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are

covered by KenPAC. Specifically excluded are: The aged, blind, and disabled categories of recipients; skilled nursing facility (SNF), intermediate care facility (ICF), and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular KMAP recipients, the KenPAC recipients will have a color-coded KMAP card with the name, address, and telephone number of their primary care provider.

Primary physician specialists or groups who may participate as primary physicians are:

General Practitioners	Obstetricians	Primary Physician Clinics
Family Practitioners	Gynecologists	Primary Care Centers
Pediatricians	Internists	Rural Health Clinics

Recipients may select a primary physician/clinic who agrees to participate in Medicaid and KenPAC. Recipients not selecting a primary physician will be assigned one within their home county. A primary physician may serve up to 1,500 KenPAC patients. Provider clinics may serve up to 1,500 patients for each full-time equivalent physician. Primary Care Centers and Rural Health Clinics may also be assigned recipients based on the number of Advanced Registered Nurse Practitioners (ARNP) they have on staff.

KenPAC primary physicians/clinics must arrange for physician coverage 24 hours per day, seven days per week. A single 24 hour access telephone number must be provided by the primary physician/clinic. This number will be printed on the recipient's KenPAC Medical Assistance Identification Card.

The following service categories must be provided either by the primary physician/clinic or referred by the primary physician/clinic in order to be reimbursed by KMAP.

Physician (excludes Ophthalmologists and Psychiatrists)
Hospital (Inpatient)(Excludes psychiatric and obstetrical admissions)
Hospital (Outpatient)

Laboratory Services
Nurse Anesthetists
Rural Health Clinic Services
Home Health Services
Primary Care Centers
Ambulatory Surgical Centers

Services not included in the above list may be obtained by the KenPAC recipient in the usual manner. These services are as follows:

Dental	Early Periodic Screening Diagnosis & Treatment
Pharmacy	
Family Planning	Obstetrical Care and Routine Newborn Care
Hearing and Vision	

Referrals may be made by the KenPAC primary physician/clinic to another provider for specialty care or for primary care during his/her absence. No special authorization or referral form is required, and referrals should occur in accordance with accepted practices in the medical community. However, to ensure that payment will be made, the primary physician/clinic must provide the specialist or other physician with his/her KMAP vendor number, which is to be entered on the billing form to signify that the service has been authorized. Claims for services provided to KenPAC recipients which do not have a referral from their primary physician will not be paid by KMAP.

"Emergency Care" is defined as a condition for which a delay in treatment may result in death or permanent impairment of health.

Pre-authorization from the primary physician is not required for emergency care. However, the primary physician should be contacted, whenever practical, to be advised that care has been provided, and to obtain the physician's authorization number. If the authorization cannot be obtained from the primary physician, the provider must contact the Medicaid Program to obtain an authorization number before submitting a claim.

"Urgent care" is defined as a condition not likely to cause death or lasting harm, but for which treatment should not wait for a normally scheduled appointment (e.g., suturing minor cuts, setting simple broken bones, treating dislocated bones, and treating conditions characterized by abnormally high temperatures).

The primary physician must be contacted for prior authorization of urgent care. If prior authorization is refused, any service provided to the client is not payable by the Kentucky Medical Assistance Program. If the recipient's primary physician cannot be reached for prior authorization, urgent care is to be provided and the necessary authorization secured after service is rendered. Under this circumstance, if post-authorization is refused by the primary physician or the primary physician cannot be contacted after service has been provided, special authorization can be obtained from the Medicaid Program. When the Program determines that the special authorization procedure is being misused, the individual provider will be advised that special authorization for further services may be refused.

Routine care in the emergency room is not to be authorized by the primary physician, and will not be payable under the Program.

KenPAC primary physicians and clinics, in addition to their normal fee for service reimbursements from Medicaid, will be paid $3.00 per month for each KenPAC patient they manage. Maximum monthly reimbursement may not exceed $3,000.00 per physician.

Any questions about the KenPAC Program may be referred to:

Manager, KenPAC Branch
Division of Policy and Provider Services
Department for Medicaid Services
275 East Main Street
Frankfort, KY 40621

Information may be obtained by calling toll free 1-800-635-2570 (In-State) or 1-502-564-5198 (In- or Out-of-State).

E. Laboratory

Laboratory services covered by the Primary Care Services element of the KMAP are limited to those procedures provided directly by the center, or if purchased, to those services covered under the independent laboratory element of the Medical Assistance Program for each participating Medicare-certified lab. The cost to the center for these services cannot exceed fees established under the KMAP.

Laboratory services must be ordered and prescribed in writing, and signed by a duly licensed staff physician, nurse practitioner or dentist, within the scope of their licensure, for the care and treatment indicated in the management of illness, injury, impairment, maternity care, or for the purpose of determining the existence of an illness or condition in a recipient. The order must be maintained within the Center's records, including the patient's file.

Laboratory tests can not be billed to EDS for services rendered to residents of skilled nursing facilities, intermediate care facilities, and intermediate care facilities for the mentally retarded and developmentally disabled, when the resident is in vendor status with the KMAP.

Procedural Coding

The coding for Laboratory procedures is found in the Health Care Financing Administration (HCFA) Common Procedural Coding System (HCPCS). Effective with services as of July 1, 1988, independent laboratory coverage was expanded to include most laboratory services that each Medicare-certified laboratory can provide. Post-mortem laboratory services are not covered.

F. Dental

Dental services are limited to those procedures covered through the Dental Services element of the KMAP. Dental services are covered for those Medicaid-eligible recipients who have not yet reached their twenty-first birthday (coverage for those turning 21 will continue through the end of their birth month). Some services are covered for Medicaid-eligible recipients aged 21 and over as well. These dental services are so designated. All services rendered to KMAP recipients must be completed prior to billing the Program for that service. This policy will be monitored through post payment review.

1. Out-of-Hospital Services: Payment for services is limited to those procedures listed on the department's dental benefit schedule, and include benefits in the following categories:

   a. Diagnostic
   b. Preventive
   c. Oral Surgery
   d. Endodontics
   e. Operative
   f. Crown
   g. Prosthetics
   h. Orthodontics
   i. Other Services

   Out-of-Hospital refers to all locations where dental services are provided, except hospital admittance. For example:

   Clinic
   Hospital Outpatient Department
   Dentist's Office
   Nursing Home
   Patient's Home

2. Out-of-Office Services: Considered to be locations where the dentist must travel away from his usual office to render professional services. For example:

   Nursing Home
   Patient's Home
   Hospital Outpatient Department

   Services listed on the Dental Procedural Coding/Benefit Schedule are applicable when rendered in out-of-office locations.

3. In-Hospital Services: Refer to dental services rendered a patient admitted to a hospital overnight. Reimbursement for inpatient dental procedures will be made to both general dentists and oral surgeons.

   A general dentist may submit a claim for hospital inpatient service for the patient termed "medically high risk." Medically high risk is defined as a patient with one of the following diagnoses:

   Heart Disease
   Respiratory Disease
   Chronic Bleeder
   Uncontrollable Patient - retardate or emotionally disturbed
   Other - automobile accident, high temperature, massive infection

   All non-emergency hospital admissions must be pre-authorized by the PEERVIEW.

To obtain prior authorization, a responsible person in the primary care center's office must contact the Peerview office at 1-800-423-6512, for a pre-admission review of proposed elective admissions. A pre-authorization code will be given to the primary care center's office by Peerview, indicating approval for the admission. A person in the primary care center's office must transmit that code to the hospital's admitting office at the time of the admission. This code allows the Peerview coordinator to certify the admission. Kentucky hospitals will not be reimbursed by the KMAP for non-emergency admissions unless the admissions were pre-authorized and certified by Peerview.

4. Procedural Coding/Benefit Schedule

The following list contains all dental services payable by the KMAP. If a service is not listed, it is not payable by the Program. Please make note of services covered for all ages and services limited to ages under 21. Services limited to ages under 21 may be billed for Medicaid-eligible recipients who have not reached their twenty-first birthday. Limitations as to the number of times a service is payable within a calendar year are indicated by procedure code.

NOTE: See Appendix XVI - Definitions of Dental Procedures

DIAGNOSTIC SERVICES (Available to all ages)

Procedure D0270 - Bitewing - Single Film

Procedure D0272 - Bitewing - Two Films

Procedure D0273 - Bitewing - Three Films

Procedure D0274 - Bitewing - Each Additional Film
Limit: A total of four (4) X-rays per patient, per 12 month period, per provider. Each of the above codes should be for one unit of service only.

Procedure D0220 - Intraoral - Periapical Single, First Film

Procedure D0230 - Intraoral - Periapical Each Additional Film
Limit: A total of fourteen (14) X-rays per patient, per 12 12 month period, per provider

Procedure D0330 - Panoramic - Maxilla and Mandible Film
Limit: One (1) per patient, per every twenty-four (24) month period, per provider

PREVENTIVE SERVICES (Available to all ages)

Procedure D1110 - Prophylaxis - Adult (Excludes Fluoride)
Note: Adult is defined as age 17 and over

Procedure D1201 - Topical Application of Fluoride (Including Prophylaxis) Children
Note: Child is defined as 16 and under

Procedure D1202 - Topical Application of Fluoride (Including Prophylaxis)
Note: Includes recipients age 17-20

Limit: One (1) per 12 month period, per patient

ORAL SURGERY (Available to all ages)

Procedure D7110 - Extraction, Single Tooth
Limit: One per tooth, per patient

Procedure D7120 - Extraction, Each Additional Tooth
Limit: One per tooth, per patient

Procedure D7130 - Root Removal - Exposed Roots
Note: Root removal is not payable on same date of service to same tooth as the tooth's extraction.

IMPACTIONS

Procedure D7210 - Surgical removal of erupted tooth, requires elevation
Procedure D7211 - Surgical removal of erupted teeth, each additional